Laina Winters, MSW, LCSW

503-314-8598

Fax: 503-472-6552

Consent for Release of Confidential Information

Client's Name: ____
Address: ______________________ City: ____________ State: _____ Zip: ________
Phone: __________________________ DOB: ____________________

I, _________________________________ , authorize ______________________________ to:
Disclose ______ (send) _______ (receive) any information, including psychiatric and psychological records, of the above named individual to Changing Seasons Counseling, Laina Winters, MSW, LCSW who is authorized to discuss all matters pertinent to the progress of the client in evaluation and treatment.

Name: ____
Address: ______________________ City: ____________ State: _____ Zip: ________

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

_____ Educational records
_____ Psychological testing results
_____ Complete medical records
_____ Behavior programs
_____ Service plans
_____ Vocational testing results
_____ Progress reports
_____ Summary reports
_____ *Psychotherapy Notes
_____ Treatment plans
_____ Drug and Alcohol records
_____ Personality profiles
_____ Psychological reports
_____ Admission & discharge summary
_____ Rehabilitation Records
_____ Other, specify ______________

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
_____ Case review
____ Updating files
____ Other (specify) ____________________

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after ______________ this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Relationship to client: ____Self ____Parent/legal guardian ____Personal representative
____Other (describe) ________________

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: ____ Date: _____/_____/______
Parent/guardian/personal representative (if applicable)
Signature: ____ Date: _____/_____/______
Witness (if client is unable to sign)
Signature: ____ Date: _____/_____/______